2010 TOP 11 SURVEY DEFICIENCIES AND RELATED DOCUMENTATION ISSUES
Bureau of Home Care and Rehabilitative Standards

This document is a summary of the most frequently written deficiencies during 2010 by the Bureau of Home Care and Rehabilitative Standards and what we as surveyors identified in your clinical record that led to these citations. This also includes the most common deficiency related to compliance with federal state and local laws.

Deficiencies written during most home health Medicare and state licensure surveys are usually directly related to:

- incomplete documentation of care and services
- incomplete or missing physician orders for all services, medications, and treatments
- inconsistent documentation – information varies on OASIS, 485, clinical notes, progress summaries and between disciplines
- vague and/or unrealistic goals for all disciplines

First, we will cover the top 11 deficiencies based on the federal Conditions of Participation and what we commonly see during survey to lead to these citations.

Deficiency #1) G158 – cited during 25% of home health surveys during 2010 – this standard says:

Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

This deficiency could include the initial plan of care, recertification plan of care and changes to the plan of care by interim physician order.

Problems identified during home visits and clinical record review related to G158 included:

- Visits for all disciplines not made at the frequency ordered on the plan of care
- No explanation for missed visits
- No documentation physician notified of missed visits and reason
- Lack of compliance with physician orders for assessment and teaching related to diabetic assessment and management, pain assessment and management, and wound assessment and care
- Lack compliance with other skilled assessment and teaching ordered by the physician
- Lack of orders for specific modalities such as heat, cold, ultrasound, electrical muscle stimulation, etc.
- Therapy orders stated as goals rather than specific procedures and modalities
- Lack of orders for changes in medications or treatments
- Lack of complete resumption of care orders post-hospitalization

Deficiency #2) G165 - cited during 20% of home health surveys during 2010 – this standard says:

Drugs and treatments are administered by agency staff only as ordered by the physician.

This deficiency can go hand in hand with G158 and the surveyor usually chooses to use one or the other tag when writing the statement of deficiencies but may write both tags depending on the specific problems identified.

Problems identified during home visits and clinical record review related to G165 includes:

- Failure to follow physician orders for medications, wound care, and other treatments ordered on the plan of care

- Patient instructed on over-the-counter medications such as laxatives; analgesics; hemorrhoid products; antibiotic, anti-fungal, or anti-itch ointments or creams; and heat or cold modalities without a physician order
- Lack of physician interim order for all laboratory tests, changes in wound care, visit frequency, and medication changes
- Lack of documentation that patient or caregiver instructed regarding changes in care such as changes in Coumadin and wound care
- Incomplete documentation of medications administered by the SN to include name of medication, dosage, route, and site of injection

Deficiency #3) G236 - cited during 20% of home health surveys during 2010 – this standard says:

A clinical record containing pertinent past and current findings in accordance with acceptable professional standards is maintained for every patient receiving home health services. In addition to the plan of a care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

Problems identified during home visits and clinical record review related to G236 includes:

- Medication list not kept updated with new or changed medications
- Skilled assessment and teaching not documented
- Incomplete and/or conflicting documentation of wounds and care provided
- Incomplete and/or conflicting documentation of pain among various disciplines
- Incomplete documentation of diabetic assessment and teaching
- Lack of physician orders
- Lack of discharge planning
- Plan of care or clinical notes missing from the clinical record
- Illegible documentation; gross spelling errors
- Incomplete or lack of summaries to the physician or discharge summaries

Deficiency #4) G118 - cited during 17% of home health surveys during 2010 – this standard says:

The home health agency and its staff must operate and furnish services in compliance with all applicable federal, state and local laws and regulations.

Problems identified during review of personnel records included lack of documentation as proof that the agency :

- Completed a criminal background check for all new employees. The criminal background check must include:
    - A criminal disclosure statement signed by the employee,
    - Employee Disqualification List check prior to hire – you cannot hire a person listed on the EDL
    - Assure employee registration with the Family Care Safety Registry prior to patient contact
    - The agency must maintain the results of the EDL check and the FCSR in the employee file

The personnel record must also include documentation to show the ageny:

- Provided training regarding Alzheimer's Disease and related dementias during employee orientation and on an annual basis
- Assured that training regarding Alzheimer's Disease and related dementias during orientation covered all required areas
- Maintained proof of Hepatitis B vaccination or a declination statement signed by the employed

Deficiency #5) G337 - cited during 16% of home health surveys during 2010 – this standard says:

The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug reactions, duplicate drug therapy, and non-compliance with drug therapy.

Problems identified during home visits and clinical record review related to G337 includes:

- No policy for medication review that identifies what method the agency will use to complete the review to assure all areas are covered
- Failure of RN to document review of medications for therapy only cases
- Failure to complete and document a medication review at each required time period for which a comprehensive assessment is required - start of care, resumption of care after hospitalization, recertification, significant change in condition and discharge
- Failure to document that all areas of the medication review were completed
- Failure to update medication list according to agency policy

Deficiency #6) G159 - cited during 16% of home health surveys during 2010 – this standard says:

The plan of care developed in consultation with agency staff covers all pertinent diagnosis, including mental status, types of service and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

Problems identified during home visits and clinical record review related to G159 includes:

- Areas of the 485 or other plan of care document are left blank
- Incomplete list of medications including OTC drugs when compared to the comprehensive assessment and medication record. May be incomplete for drug, dosage, frequency, and/or route of administration
- Orders for therapy or social work evaluations obtained during referral or the initial visit are not included on the plan of care
- Incomplete physician orders for wound care, IV dressings, flush solutions, sliding scale insulin, frequency of blood sugar checks to be performed by patient, nutritional requirements, and functional limitations
- The goals were not measureable or specific to problems identified during the comprehensive assessment
- The Plan of Care, either initial or recertification, was not developed and sent to the physician for review and signature in a timely manner, according to agency policy

Deficiency #7) G145 - cited during 9% of home health surveys during 2010 – this standard says:

A written summary for each patient is sent to the attending physician at least every 60 days.

Problems identified during clinical record review commonly cited under G145 include:

- No summary was written or sent to the physician at least every 60 days
- A prepared summary was found in the clinical record but the agency failed to maintain documented proof that the summary was sent to the physician
- The summary failed to include the dates covered
- The summary contained incomplete information about all services provided and patient's response during the dates covered

Deficiency #8) G224 - cited during 8% of home health surveys during 2010 – this standard says:

Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide.

Problems identified during home visits and clinical record review related to G224 includes:

- RN failed to put information on the aide assignment sheet pertinent to patient care such as frequency of visits, oxygen needs, wounds and aide responsibility, nutrition requirements when meal preparation assigned, need for gait belt, walker, cane or Hoyer lift, etc
- RN failed to document during supervisory visits whether or not the aide is actually following the assignment
- RN failed to update the aide assignment for changes in patient's condition or needs
- Aide failed to follow written aide care plan or assignment evidenced by aide documentation or observation of services being provided by the aide during a home visit

Deficiency #9) G143 - cited during 7% of home health surveys during 2010 – this standard says:

All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.

Problems identified during home visits and clinical record review related to G143 includes:

- Failure of RN and LPN to show coordination of services by documentation of communication regarding changes in patient condition or needs including new physician orders for medications and treatments
- No documentation of coordination between therapies, nursing and aide regarding patient falls, new or changed medications or treatments, changes in patient's condition, or pain management
- PT, OT, ST, or MSW services not started in a timely manner

Deficiency #10) G108 – cited during 7% of home health surveys during 2010 – this standard says:

The patient has the right to be informed in advance about the care to be furnished and of any changes in the care to be furnished. The home health agency must advise the patient in advance of the disciplines that will furnish care and the frequency of proposed visits. The home health agency must advise the patient in advance of any change in the plan of care before the change is made.

Problems identified during home visits and clinical record review related to G108 includes:

- During the admission, the agency failed to provide written documentation of the disciplines that will provide care and the proposed frequency of visits
- Lack of documentation of discharge planning
- Lack of documentation to show the patient was informed of increase or decrease in frequency of visits
- Lack of documentation to show patient informed of changes in medications or treatments such as changes in Coumadin dosages and changes in wound care
- Agency failed to follow agency policy for use of the Home Health Advance Beneficiary Notice or Notice of Medicare Provider Non-Coverage

Deficiency #11) G229 - cited during 7% of home health surveys during 2010 – this citation is part of the standard for supervision of the home health aide. G229 states:

The registered nurse or (another professional described in paragraph (d) (1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.

Problems identified during home visits and clinical record review related to G229 includes:

- Aide supervisory visits are not documented at least every 14 days
- On-site visits were not actually made on the dates documented
- Telephone calls used instead of on-site visit
- Aide supervision documented when no home health aide assigned

DOCUMENTATION TIPS TO AVOID DEFICIENCIES
Bureau or Home Care and Rehabilitative Standards

You must be able to defend your documentation to show quality of care during state surveys, medical review by your fiscal intermediary, and even in a court of law. The Office of Inspector General has said that documentation is the biggest issue for home health. Remember the old practice standards adage – "If it's not documented – it didn't happen." Some general tips for documentation are included on the attached table, **"Defensive Documentation Tips."**

Four of the most common documentation problems encountered during the survey process deal with assessment and teaching of diabetic care, pain management, wound care, and summaries to the physician. The following are tips developed by the survey staff.

#1) Diabetic Assessment and Management – if the primary or secondary diagnosis is diabetes and diabetic interventions and goals are included on the plan of care, there are specific things that should be documented in the clinical record.

- When completing the comprehensive assessment – assess and document the patient or caregiver's baseline knowledge of the disease process of diabetes – this is your basis for further teaching
- Document if the patient has a glucometer and if he/she knows how to use it. If the patient is unable to use the glucometer is there a caregiver who checks the blood sugars
- Assess and document how often the patient checks the blood sugar and what the blood sugars have been running
- Is the Patient or caregiver able to fill syringes and administer insulin
- Is the Patient compliant with oral diabetic medications and insulin administration
- What is the patient's level of knowledge regarding diet restrictions
- Document high risk drug teaching related to diabetic medications and what problems to report to the physician
- Assess and document on the 485 when the physician wants patient to check blood sugar and the parameters for reporting abnormal readings. If on sliding scale insulin, the physician order must include the specific dosages to be administered for specific blood sugar readings and the frequency of testing/administration
- During subsequent visits develop a systematic method to assess and document:
  - Blood sugar trends since previous SN visit. If blood sugars are assessed more than one time daily then your assessment should be documented specific to the times of day the patient tested the blood sugars
  - If the patient reports abnormal BS readings, assess and document events that may have contributed to abnormal readings such as diet, illness, or failure to take medication. Report readings outside of established parameters to the physician.
  - Document compliance with oral diabetic agents, insulin and/or use of sliding scale insulin
  - Teach diabetic management based on needs identified during the initial visit. Teaching may include use of glucometer, injections, specific elements of the diabetic diet, sick day management, proper foot care, prevention, and treatment of hypo or hyper glycemia, disease process and complications, when to report problems
  - Document your specific teaching the patient level of understanding. This is important when repeated teaching is needed

#2) Pain Assessments and Management

- Pain should be assessed and documented by nursing and therapies
- Document pain as part of the initial comprehensive assessment and all follow-up visits. The documentation should include –

- The location of pain, type and quality of pain
- The pain should be rated using a standardized pain scale
- Document the history of pain - this may be a 24 hour recall or pain since last SN visit
- if you document "no pain at present time" still document a history to determine if the patient truly has no pain or if the patient's pain is well controlled with the prescribed regimen
- Document specific medication or medications used and how often the patient used each medication and the effectiveness
- At the start of care you should have determined the patient's goal for pain control
- Consistently assess and document if the patient is satisfied with the level of pain control
- Document coordination with the physician and between disciplines if pain goals are not met
- The SN should document patient and caregiver education and level of understanding regarding pain and symptom management and the medication regimen
- Don't forget to document non-pharmacological methods of pain control and the effectiveness of use of ice, heat, TENS, massage, meditation, etc that were ordered by the physician

#3) Wound Assessments and Care

- Documentation for assessment of wounds is required as part of each comprehensive assessment and then as often as your agency policy states. Usually we see wounds completely assessed including measurements at least one time a week and with any changes in treatment.
- Complete wound assessment documentation should include:
  - Location of wound – if multiple sites, use consistent location descriptors or a consistent numbering system
  - Measurements – be consistent using cm or inches
  - Document the presence of tunneling or undermining
  - Appearance – color of wound bed and surrounding tissue
  - Drainage – color, type, and amount
  - Odor
- Remember – Only pressure ulcers are staged. Do not down-stage pressure ulcers as they heal
- Documentation of wound assessment at each visit should include at a minimum location, appearance, odor, and drainage
- Documentation of the wound care performed by the SN should include:
  - The specific treatment done to each wound including the cleansing agent used, products applied to wound bed and surrounding area, and the type of dressing applied
  - If your agency documents "wound care per physician's order" you MUST specify the date of the order you are following
- Physician orders for wound care should include:
  - Location of wound
  - Cleansing agent
  - Medication or specific product to be applied to wound bed or surrounding area
  - Type of dressing
  - Method of securing dressing
  - Frequency of dressing change
  - Who will be taught to do dressing change in the absence of the SN
- For multiple wounds with different wound care, orders should be specific for each wound
- Before the patient or caregiver independently provides wound care the SN should document teaching including a return demonstration of the dressing change procedure. At subsequent visits the SN should assess and document if the patient or caregiver is compliant with the dressing change as ordered by the physician

#4) 60 – Day Summary to the Physician

- A separate progress summary is no longer required. The 60-day summary to the physician will be accepted by the surveyors as both the progress summary and the summary to the physician. Per the Conditions of Participation, the federal definitions for clinical note, progress note, and summary report are:
  - Clinical note – means a notation of a contact with a patient that is written and dated by a member of the health team and that describes signs and symptoms, treatments and drugs administered, and the patient's reaction and any changes in physical or emotional condition.
  - Progress note – means a written notation dated and signed by a member of the health team that summarizes facts about care furnished and the patient's response during a given period of time.
  - Summary report – means the compilation of the pertinent factors of a patient's clinical notes and progress notes that is submitted to the patient's physician.
  - The interpretive guidelines for the Conditions of Participation state the regulations do not dictate the form to be used as a progress note or summary report. Notations should be appropriately labeled and should provide an over-all comprehensive view of the patient's total progress including social, emotional, or behavioral adjustments relative to the diagnosis, treatment, rehabilitation potential and anticipated outcomes toward recovery or further debilitation.
- When preparing your 60-day summary to the physician it should include:
  - The dates covered by the summary
  - Information from all disciplines that saw the patient during the certification period
  - Include clinical facts pertinent to your plan of care such as ranges of vital signs, blood sugars, lab values, medication changes, wound appearance, progress toward healing, changes in wound care, progress toward therapy goals, changes in therapy plan of care, psycho-social or environmental changes, etc
  - The 60-day summary must be a summary of the entire 60 day period and not just a summary of the last visit findings
  - Documentation must show that the 60-day summary was sent to the physician and the date sent

DEFENSIVE DOCUMENTATION TIPS	
DO NOT	**DO**
➢ **Make generalized statements** "Patient states pain is better. Pain medication used."	➢ **Be specific and factual** "Patient rated pain in left lower leg at 2 of 10 at present. Worst pain has been in past 24 hours is 6. Vicodin 5/325mg one tablet used 2 times in past 24 hours with decrease in pain to 2. Patient satisfied with pain control."
➢ **Avoid non-descriptive words such as stable, normal, within normal limits** "Diabetic status is stable within normal limits."	➢ **Use objective patient stated documentation to describe disease process and progress toward goal** "Patient reported checking blood sugar morning and evening. For past 5 days blood sugars in AM have been 82 – 175. PM blood sugars 100 -200."
➢ **Do not document general statements of coordination.** PT documented, "Conferenced with SN."	➢ **Be specific. Document who you spoke with regarding care issues. Be specific about issue discussed, care plan problems, interventions and outcomes.** "Susie RN notified of elevated blood pressure of 200/104 and pulse rate of 102. Patient stated saw doctor yesterday and medication changed. Norvasc increased from 5 mg daily to 10 mg daily. RN will notify physician."
➢ **Use standard goals and interventions on care plans and progress notes.** "Patient cardio-respiratory status will be within normal limits for patient." "Patient pain will be improved."	➢ **Individualize care plan per patient/family issues, needs, goals and outcomes.** Use physician or agency established parameters for vital signs and blood sugars. Use patient stated goals for pain control. Relate goals to what the patient wants to be able to do when status is improved.
➢ **Do not use judgmental language such as non-compliant, inadequate, dysfunctional, inappropriate** "Patient is non-compliant with his pain regimen."	➢ **Describe behaviors and events to paint a picture.** "Patient refuses to use Vicodin 5/325mg every 6 hours for pain rated at 4/10. Patient stated Vicodin caused upset stomach and dizziness."
➢ **Identify an issue, problem or concern and fail to address it in subsequent and ongoing contacts**	➢ **Review previous visit notes. Address previously identified problems and document resolution.**

DO NOT	DO
➢ Use unknown abbreviations	➢ Use only approved abbreviations which have been authorized by your organization
➢ Use whiteout or writeovers	➢ Follow agency policy for correcting documentation errors
➢ Rely on memory	➢ Document as close as possible to the time of service delivery